

# Barriers and Facilitators to Family Planning Access in Canada

## Obstacles et facilité d'accès à la planification familiale au Canada



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## Abstract

*Background:* Contraceptives are underutilized in Canada, and nearly one in three Canadian women will have an abortion in her lifetime. To help delineate a national family planning research agenda, the authors interviewed healthcare providers and organizational stakeholders to explore their perspective on barriers to contraception across regions of Canada.

*Methods:* Semi-structured interviews were conducted based on validated frameworks for assessing family planning access and quality. The authors purposefully selected 14 key stakeholders from government agencies, professional organizations and non-governmental organizations for in-person interviews. Fifty-eight healthcare providers and representatives of stakeholder organizations in reproductive health who self-selected through an online survey were also interviewed. Transcripts were analyzed for repeated and saturated themes.

*Results:* Cost was the most important barrier to contraception. Sexual health education was reported as inconsistent, even within provinces. Regional differences were highlighted, including limited access to family physicians in rural Canada and throughout Quebec. Physician bias and outdated practices were cited as significant barriers to quality. New immigrants, youth, young adults and women in small rural, Northern and Aboriginal communities were all identified as particularly vulnerable. Informants identified multiple opportunities for health policy and system restructuring, including subsidized contraception, and enhancing public and healthcare provider education. Sexual health clinics were viewed as a highly successful model. Task-sharing and expanded scope of practice of nurses, nurse practitioners and pharmacists, alongside telephone and virtual healthcare consultations, were suggested to create multiple points of entry into the system.

*Conclusion:* Results underscore the need for a national strategic approach to family planning health policy and health services delivery in Canada.

## Résumé

*Contexte :* Les contraceptifs sont sous-utilisés au Canada; près d'une Canadienne sur trois subira un avortement au cours de sa vie. Pour aider à définir un programme national de recherche sur la planification familiale, les auteurs ont interviewé des fournisseurs de services de santé et des responsables d'organismes afin de connaître leurs points de vue sur les obstacles à la contraception dans différentes régions du Canada.

*Méthode :* Des entrevues semi-dirigées ont été menées, selon des cadres de travail validés, afin d'évaluer la qualité et l'accès à la planification familiale. Les auteurs ont volontairement choisi, pour des entrevues directes, 14 intervenants clés provenant d'agences gouvernementales, d'organisations professionnelles et d'organisations non gouvernementales. Les auteurs ont également interrogé 58 fournisseurs de services de santé et représentants d'organisations (qui se sont portés volontaires lors d'un sondage en ligne) œuvrant dans le milieu de la médecine de la procréation. Les transcriptions ont été analysées pour en dégager les thèmes récurrents et saturés.

*Résultats* : Le coût est le principal obstacle à la contraception. L'éducation en matière de santé sexuelle est incohérente, même au sein d'une province. Des différences régionales ont été soulignées, notamment l'accès limité aux médecins de famille dans le Canada rural et partout au Québec. Le biais des médecins et des pratiques désuètes ont été indiqués comme d'importants obstacles à la qualité. Les nouveaux immigrants, les jeunes, les jeunes adultes et les femmes dans les petites communautés rurales, du nord et autochtones sont tous des groupes identifiés comme étant particulièrement vulnérables. Les personnes interrogées ont indiqué plusieurs points propices à une restructuration politique et systémique, notamment sur la question des subventions à la contraception et de l'éducation auprès de la population et des fournisseurs de services de santé. Les cliniques de santé sexuelle sont considérées comme un bon modèle de succès. Le partage des tâches et un champ de pratique élargi pour les infirmières, les infirmières praticiennes et les pharmaciens, de même que des consultations téléphoniques et virtuelles, sont proposés comme moyens de créer plusieurs points d'entrée dans le système.

*Conclusion* : Les résultats font voir le besoin d'une approche stratégique nationale pour la prestation de services et pour les politiques de planification familiale au Canada.

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## Background

As the average age at first birth in Canada nears 30, young Canadians are now passing nearly half their reproductive life span before bearing children (Statistics Canada 2011). Access to the knowledge, services and methods for reliable contraception is an important concern. Women aged 20–29 years continue to represent over half of all those undergoing abortion, and nearly one in three Canadian women will have an abortion at some time in her life (CIHI 2012). Health and social disparities add additional risks to pregnancies and births resulting from unintended conceptions (Frost et al. 2008).

Contraceptives are underutilized: among heterosexual sexually active Canadians not intending to conceive, 15% use no contraception at all, and withdrawal remains the third most used contraceptive method in Canada (Black et al. 2009; Stubbs and Schamp 2008; WHO 2006). Vulnerable populations, including youth and those of low socioeconomic status, are disproportionately affected by unintended pregnancy and abortion, raising concerns about their access to quality contraceptive education and healthcare (Fisher and Black 2007; Saewys et al. 2008). Quality in family planning services has been described as “the way individuals and clients are treated by the system providing services” (Bruce 1990; Jain 1989), and includes access to services. Bertrand and colleagues further developed the concept of access to include the distance clients must travel, the costs, the attitudes of providers and unnecessary administrative barriers (Bertrand et al. 1995). Little is known about access and quality of contraceptive services in Canada and what barriers vulnerable populations experience to meet their contraceptive needs. Members of our network of family planning researchers, the

Contraception Access Research Team/Groupe de recherche sur l'accessibilité à la contraception (CART–GRAC), undertook a national consultation with leaders of professional organizations, organizations representing disadvantaged women's groups and healthcare providers working in the area of women's health. We aimed to identify gaps and opportunities for equitable access to knowledge, services and methods of family planning in Canada. Findings will contribute to the foundation of a national family planning research agenda to inform evidence-based health policy and health services planning.

## Methods

This qualitative study (Neergaard et al. 2009) was nested within a national consultation on access and quality of family planning services. CART–GRAC's national bilingual on-line survey on contraceptive access, developed based on theoretical frameworks of Bertrand et al. and Bruce and Jain (Bertrand et al. 1995; Bruce 1990; Jain 1989), is reported elsewhere (Norman and Dunn 2012). This study elicited the views of government agencies, professional organizations, non-governmental organizations and professionals from disciplines involved in sexual healthcare delivery on the most important barriers for access to and quality of contraceptive services, and to suggest solutions.

### *Study setting*

Face-to-face interviews were conducted in Ottawa, Quebec and Toronto between August and November 2011. Telephone interviews were conducted between January and May 2012.

### *Study participants*

Our goal was to obtain a purposeful national sample of respondents that reflected a variety of professional viewpoints across Canada, and incorporate the perspectives of disadvantaged populations, and providers working in the area of sexual health. We recruited key stakeholders from government agencies, professional organizations (medicine, nursing and pharmacy), advocacy and not-for-profit groups for in-person interviews with our research team.

Additionally, we recruited the respondents to CART–GRAC's national bilingual on-line survey, which was initially distributed through established organizations across Canada representing women's health issues, groups providing healthcare to vulnerable populations and key provincial and national agencies with a focus on family planning issues. These organizations in turn distributed the survey through their professional networks (Patton 1990). If respondents consented to be contacted for a semi-structured telephone interview, they were contacted by phone to participate in this study.

### *Data collection*

The interview guide was based on two foundational frameworks on access and quality of family planning services (Table 1) (Bertrand et al. 1995; Bruce 1990; Jain 1989). Questions

elicited participants' perspectives on key barriers and solutions to improving access to and quality of family planning under each domain of the framework.

**TABLE 1.** Theoretical frameworks for access and quality in international family planning

Key domains of access: (Bertrand et al. 1995)	Key domains of quality: (Bruce 1990; Jain 1989)
1. Cognitive: awareness of services, public knowledge 2. Administrative: health system delivery barriers, schedules and wait times, medical barriers – including attitudes of providers and unnecessary eligibility requirements 3. Economic: cost of services 4. Geographic: distance clients must travel to reach services 5. Psychosocial: sociocultural barriers, stigma, fear of pelvic examinations and confidentiality	1. Choice of contraceptive methods 2. Information given to clients 3. Technical competence 4. Interpersonal relations 5. Continuity and follow-up Appropriate constellation of services

Members of the research team (W.N., E.G., J.S., S.D.) conducted face-to-face interviews with 12 purposefully selected stakeholders, with an additional two interviews conducted by telephone (the interviews took between 20 and 45 minutes). The two modalities are considered equally valid, comparable data collection methods (Patton 1990). Interviewers used handwritten notation to record interview responses.

Two members of the research team (J.H., Research Assistant) conducted semi-structured interviews by telephone in either English or French with the online survey respondents who volunteered to be interviewed. Fifteen interviews were professionally transcribed, and the remainder were transcribed and translated by J.H. due to resource limitations.

One reviewer (J.H.) organized and coded the transcripts through multiple readings to identify meaningful patterns, while also noting discordant views (Guest et al. 2011). TamsAnalyzer® software was used to organize thematic analysis. Predominant themes were periodically reviewed with the research team for input and classification.

Ethics approval was obtained from The University of British Columbia Children's and Women's Hospital Behavioural Research Ethics Board (H11-02495). Verbal informed consent was obtained from each participant. Pseudonyms were used during transcription to ensure anonymity.

## Results

In addition to 14 chosen key stakeholders, 17 of the 17 managers and organization leaders and 41 of the 53 healthcare providers who had indicated in the online survey their interest in being interviewed participated, for a total of 72 interviews. Informant demographics are outlined in Table 2.

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**TABLE 2.** Informant demographics

	Language of correspondence	
	English (N = 53)	French (N = 19)
<b>Professional category</b>		
Nurses, midwives and nurse practitioners providing reproductive health services	14	6
Family physicians/paediatricians providing reproductive health services	6	2
Physicians performing medical and/or surgical abortion	3	1
Other (sexual health counsellors, social workers, psychologists, support workers)	2	
Health Service Administrators, abortion and reproductive health services (often also practicing clinicians)	6	2
Managers, public health agencies (regional and national)	6	
University-based clinician researchers	4	
University-based medical/health professional educators	3	
Directors, organizations representing women and vulnerable populations	2	5
Leaders, Provincial and National reproductive health organizations	3	1
Leaders, Health professional organizations	4	2
<b>Province/territory</b>		
Yukon	1	2
Northwest Territories	1	
British Columbia	13	
Alberta	2	
Saskatchewan	1	
Manitoba	3	
Ontario (including Ottawa-based national organizations)	22	
Quebec	3	15
New Brunswick	2	2
Nova Scotia	5	

Predominant concepts and themes are summarized in Table 3, and outlined in the following text.

**TABLE 3.** Barriers to comprehensive family planning access and proposed solutions

Barriers	Solutions
<b>Cost</b> <ul style="list-style-type: none"> <li>• Cost of contraception is one of the primary barriers to access nation-wide</li> <li>• Provincial and private insurance plans often limit access to the full range of contraception options</li> <li>• High up-front cost of the intrauterine system (IUS)</li> <li>• Prohibitive cost of travel, accommodation, abortion procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Universally subsidize contraception through public financing and mandated, regulated insurance</li> <li>• Specifically find ways to subsidize the IUS/IUD</li> <li>• Expand travel assistance programs and establish provincial reciprocal agreements for abortion procedures and IUD insertions</li> <li>• Look to Quebec for financing models</li> </ul>
<b>Knowledge among the general public</b> <ul style="list-style-type: none"> <li>• Weak and highly variable sexual health education across the country, with regional variability between and within provinces</li> <li>• Efficacy and the long-term effects of hormonal contraception and the IUD are poorly understood</li> </ul>	<ul style="list-style-type: none"> <li>• Prioritize early sexual education in schools as the cornerstone for boosting public knowledge</li> <li>• Tailor accurate online and social media resources to youth, Aboriginal Canadians, new immigrants and people with disabilities</li> <li>• Pilot confidential phone line and text messaging services for Native communities and other groups for reproductive health questions</li> <li>• Standardize interprofessional pre- and postgraduate education in evidence-based family planning, including surgical and medical abortion</li> <li>• Require continuing education programs for allied health professionals and community actors similar to the Quebec Institute of Public Health online contraceptive training program</li> </ul>
<b>Healthcare provider competence</b> <ul style="list-style-type: none"> <li>• Inappropriate prescribing patterns and outdated contraindications to birth control methods</li> <li>• Reproductive health limited in medical and nursing curricula</li> <li>• Limited scope of practice for FPs, nurses and midwives. Shortage of providers inserting IUDs.</li> </ul>	
<b>Healthcare provider attitudes</b> <ul style="list-style-type: none"> <li>• Bias against specific groups, like adolescents, or against prescribing any form of contraception</li> <li>• Refusing referral for abortion, resulting in delays, notably in the Yukon, Prince Edward Island and New Brunswick, which require physician referrals</li> <li>• Lack of unbiased and confidential providers for contraception and abortion care available in northern and small communities</li> </ul>	
<b>Health system access</b> <ul style="list-style-type: none"> <li>• Limited access to regular primary care providers nation-wide, especially in small to medium-sized towns and throughout Quebec</li> <li>• Fee-for-service compensation and rushed patient scheduling limits the quality of comprehensive family planning counselling</li> </ul>	
<b>Vulnerable populations</b> <ul style="list-style-type: none"> <li>• Rural, remote and Aboriginal communities lack confidential and unbiased care</li> <li>• Youth and young adults transitioning out of the formal education system cannot confidentially use their parents' insurance</li> <li>• New immigrants and the working poor lack coverage if they are not on income assistance</li> </ul>	<p><b>Create multiple points of entry into the system through:</b></p> <ul style="list-style-type: none"> <li>• Specialized reproductive health services, including drop-in sexual health and youth clinics, open during evenings and weekends. Include rural areas and Aboriginal communities. Consider mobile clinics.</li> </ul> <p><b>Expand the range of family planning providers through task sharing and expanded scope of practice of allied health professions</b></p> <ul style="list-style-type: none"> <li>• Advocate for expanded scope of practice recognized by governing bodies of allied health professionals</li> <li>• Measure the impact of existing task-sharing agreements in Alberta, Quebec, Ontario and British Columbia</li> <li>• Expand the study to include the impact of select methods available over the counter</li> </ul> <p><b>Telephone and virtual healthcare consultations</b></p> <ul style="list-style-type: none"> <li>• Utilize telephone consultations among nurses, pharmacists and midwives to obtain authorization for contraception in rural areas</li> <li>• Pilot task-sharing options and Internet medical consultation for rural medical abortion</li> </ul>

### Barriers to access

#### COST BARRIERS

The cost of contraceptive methods was the most important barrier to family planning cited by informants. Women who are least able to afford contraception are also least likely to be insured. Participants shared stories of sacrifice and unwanted pregnancies owing to the cost of contraceptives, especially among adolescents, young adults no longer eligible for youth clinics,

immigrants and the working poor. “*But it’s in between ones, the working poor, who just – they just can’t afford that.*” (Nurse Practitioner, Ontario). This often results in these groups “*abandoning birth control en route*” (Nurse, Quebec).

Traditionally, sexual health clinics have tried to reduce the cost barrier by offering subsidized low-cost contraceptives. However, “The cost of contraceptive medications, even at a cheaper, compassionate rate, are continually going up and up and up” (Manager, Health Unit, Ontario), and organizations reported spending a growing portion of their budgets to subsidize contraception. The Society of Obstetricians and Gynecology of Canada compassionate care program is limited because “*Physicians either don’t know about it, or they find the [paperwork] rather onerous.*” (Sexual Health Nurse, Ontario). Respondents were also concerned that insurance plans excluded certain contraceptive methods. Quebec’s pharmacare plan and many private insurance schemes exclude the copper intrauterine device (IUD) on the basis that it is not a drug. Other third-party schemes only cover the intrauterine system (IUS) for heavy menstrual bleeding, but not for contraception. Informants specifically highlighted that the prohibitive up-front cost of the IUD/IUS should be addressed.

“We have to make the IUD and long-term methods more accessible to the public, because if you don’t have a family doctor, at least you have five years to find one.”  
(Nurse, Quebec)

The cost of travel and accommodation and the cost of therapeutic abortion itself in private abortion clinics were reported as major barriers for Canadian women living outside of urban areas. Reciprocal agreements between provinces to cover the costs of therapeutic abortion are lacking. The exception was among respondents in Quebec, who reported fewer cost barriers, and far fewer barriers as a whole to abortion care.

#### INCONSISTENT SEXUAL HEALTH EDUCATION AMONG THE GENERAL PUBLIC

Informants cited schools as the cornerstone for public family planning knowledge, but noted inconsistent sexual education as a common problem in schools. Those working with strong school sexual education programs saw this as a major strength, whereas weak school programs were seen as contributing to major knowledge gaps. School curricula were often characterized as: “*not standardized, taught by some teachers that don’t want to talk about it, a very small number of hours, and not a very good program*” (Public Health Nurse, British Columbia). Regional variability between and within provinces was highlighted. New Brunswick informants, for example, identified sexual health knowledge as lacking among Anglophone women compared to Francophones, acknowledging better quality sexual education in the French-language school system.



#### INCORRECT AND OUTDATED KNOWLEDGE OF CONTRACEPTION AMONG HEALTHCARE PROVIDERS

Antiquated beliefs or biases towards certain contraceptive methods were widespread among healthcare workers, according to many informants. They cited a tendency to prescribe oral contraceptive pills over other methods, even when women were having difficulty taking a daily pill on time.

“I had a patient the other day whose physician refused her Depo-Provera because she was a teenager. ... because I spoke to her after she had her baby, and I said, ‘What birth control would you like?’ and she says, ‘Well, I’d like the needle, but they told me I wasn’t a good candidate.’ She ... received poor information from her healthcare provider. And she ended up pregnant, consequently.” (Nurse Practitioner, Manitoba)

Outdated contraindications to birth control methods included women being encouraged to “take a rest” from hormonal contraception, providing three or six months of contraception prescriptions to encourage frequent reassessments and denying hormonal contraception to all women over 35 regardless of risk factors. There was also a pervasive misperception that IUDs cannot be used in nulliparous women.

Informants in Prairie Provinces expressed concern that reproductive health was no longer a mandatory part of medical and nursing curricula, with a resulting narrow scope of practice that often excludes IUD insertions. Quebec informants, for example, indicated that gynaecologists were the only practitioners inserting IUDs in some parts of the province, and sexual health centres in Manitoba receive referrals from family physicians for IUD insertions.

#### NEGATIVE PHYSICIAN ATTITUDES AND CONFLICTS WITH PERSONAL BELIEF

Respondents described a number of experiences with physicians who refused to prescribe contraception, either by targeting specific groups such as adolescents, or refusing to provide contraception altogether, which was described as particularly affecting women living in rural areas who “...are unable to be picky about who can work in these communities” (Manager, Northern Health Services).

“We have a physician in our county who will not prescribe birth control because he doesn’t believe in it. So for religious reasons ... [he] puts his women patients in a spot. We have a doctor shortage in our county. They can’t change doctors, and the College of Physicians and Surgeons tell him it’s okay. He doesn’t have to prescribe it. If he doesn’t believe in it, he doesn’t have to.” (Family Physician, Saskatchewan)

In Prince Edward Island, New Brunswick and the Yukon, where women require referrals for abortion services, as well as rural and Northern communities, informants described difficulty in finding a physician who will refer, with resulting delays in abortion care.

“She went to the walk-in clinic and the doctor there said – he said, ‘Oh, well, you might as well keep the baby. Do you know how hard it is to get pregnant?’ and she was crushed, terrified, upset, didn’t know what to do. Because she went for help and this man told her that – ‘You’re lucky to be pregnant. Why would you want to get rid of it?’” (Family Physician, New Brunswick)

### *System barriers to health service delivery*

Many Canadians do not have a regular primary care provider, and “*where else are you going to go for contraception?*” (Family Physician, Saskatchewan). Informants at all levels in Quebec cited difficulty accessing a family physician as *the* major barrier to contraception. This deficit was echoed in the Prairie and Maritime Provinces, where young adult women have even greater difficulty finding a primary care provider.

Fee-for-service compensation and rushed patient scheduling were faulted for a lack of appropriate family planning counselling from physicians, underpinning the bias against methods (other than oral contraceptive pill) that require time to explain, or against IUD insertion, which may not be well-compensated. Physicians were perceived as “*dealing with contraception like you deal with the common cold, take these pills every day and you’ll be fine, without the targeted counselling required*” (Nurse, British Columbia).

“This is ridiculous that we’ve got doctors working as businessmen, you know, and that ... kids need – youth especially – sometimes need a 45-minute visit to go over birth control so that they’ll use it effectively. And a 45-minute visit is not realistic in a family clinic that’s fee-for-service.” (Nurse Practitioner, British Columbia)

### *Special needs of vulnerable populations*

A number of populations were identified as particularly vulnerable to barriers related to confidentiality, quality of care, healthcare provider bias, geography and cost.

Rural, Northern and Aboriginal communities face a unique set of challenges related to provider attitudes. These patients have very limited choice in healthcare providers and are not assured confidentiality in settings where they may know everyone working at the clinic.

“In the north, the access – cost is not the issue. It’s access, it’s confidentiality ... these are the issues in the north.” (Manager, Northern Health Services)

Many informants offered anecdotes of women hitchhiking hours to find a provider willing to refer them for abortion, or to seek non-judgmental contraception care. Stories emerged of women’s families discovering they were pregnant before they had even returned from the clinic, or blocking the passage of the plane destined to a referral centre for therapeutic abortion.

In addition to significant geographical barriers and the lack of service providers, informants who work closely with Aboriginal populations suggested much of the messaging about family planning remains culturally irrelevant, focused on “preventing births” rather than “planning the family.” Informants also highlighted the lack of tailored, culturally relevant outreach to new immigrants.

Across Canada, informants reported that young adults who transition out of the formal education system are left without sexual health education or access to the sexual health services typically associated with educational institutions. Young adults who no longer qualify for “youth services” are especially vulnerable. Some government and health institutions respond to this by trying to alter the definition of “youth” to 25 or 30 years of age to serve these clients.

“So what we see a lot of is the late teens, early twenties, who are working, often part-time jobs, often minimum wage, maybe they’re going to school part-time desperately trying to not be pregnant at the same time, and really that 20 dollars a month is a struggle for them to be on birth control. And there’s no subsidy for these youth.”  
(Nurse Practitioner, British Columbia)

#### *Findings related to recommendations for health system improvements*

Participants identified a number of concepts and strategies for addressing gaps in access and quality.

#### FREE OR SUBSIDIZED CONTRACEPTION

Almost *every* informant, from healthcare workers to decision-makers, emphasized that the full range of contraceptive methods should be made freely available, or at a highly subsidized cost through public financing or through mandated, regulated insurance. Several participants specifically cited Quebec as a potential model, where youth under 18 years and youth aged 19–25 who are still students living with their parents can access free contraception, and there is a universal provincial drug insurance plan with a small monthly deductible.

“In my opinion, all contraception should be at extremely low cost, like one dollar for birth control pills or IUDs. Indeed, in my office last week, I had a young woman who wants to have an IUD, and she cannot afford it. She does not have 200 dollars for an IUD. And so she is using withdrawal method. I was appalled that this is happening now .... I’ve been in medicine for 40 years, and things have not improved ... very much in those 40 years. So in my opinion, the government or somebody should subsidize all contraception to make it as cheap as possible so it’s easy to access for all women.”(Family Physician, British Columbia)

MULTIPLE POINTS OF ENTRY INTO THE SYSTEM

To overcome barriers faced by vulnerable populations, including regional disparities, the lack of accessible, quality healthcare providers, and the provider attitudes that restrict access, respondents suggested multiple means of accessing reproductive care.

*SPECIALIZED REPRODUCTIVE HEALTH SERVICES.*

“Having clinics whose sole purpose is ... women’s reproductive care is one way of ensuring that it’s a safe place for women to come and be able to ask anything and be provided with unbiased information.” (Sexual Health Educator, British Columbia)

Respondents, from stakeholder organizations to service providers, endorsed specialized sexual health clinics as an appropriate strategy because they answer to the “who, when, how” of accessing timely services and knowledgeable practitioners and assure confidentiality and non-biased providers. Informants working with Aboriginal populations and youth specifically cited drop-in family planning clinics open on weekends as a “best practice,” and imperative for young people outside of the formal education system or who no longer qualify for youth clinics. Suggested program models include Options for Sexual Health clinics in British Columbia, Planned Parenthood information services and clinics in other parts of Canada and maintenance of the “Cliniques de Planning” in Quebec.

*EXPAND THE RANGE OF FAMILY PLANNING PROVIDERS THROUGH TASK SHARING AND EXPANDED SCOPE OF PRACTICE OF ALLIED HEALTH PROFESSIONS.*

Respondents advocated for broadening the scope of practice of nurse practitioners, registered nurses and pharmacists to help bypass access barriers to reproductive health services. “*There’s no reason I see why nurse practitioners couldn’t do medical abortions – we already do IUD insertions and we manage miscarriages within our scope of practice*” (Nurse Practitioner, British Columbia). A number of key stakeholders and healthcare providers specified that contraceptives should be provided over the counter, citing recent, positive experience with behind-the-counter emergency contraception. Stakeholders from national and provincial medical, nursing and pharmacy professional organizations generally expressed openness to collaborating with each other for expanded scope of practice among allied health professionals. One model cited is the Collaborative Agreement on Hormonal Contraception in Quebec, which allows a certified nurse or pharmacist to initiate hormonal contraception (OIIQ 2012). Nurses stressed the imperative to expand the duration and responsibility of nurses in family planning, given how many women are still unable to find a family physician.

#### UTILIZE TELEPHONE AND VIRTUAL HEALTHCARE CONSULTATIONS.

Informants suggested telephone consultations among allied healthcare professionals to obtain authorization for contraception, such as the 24-hour telephone consultation services like HealthLink in Alberta and British Columbia or Info-Santé in Quebec. A few respondents also suggested piloting Skype and telephone consultations to expand access to medical abortion care. Confidential hotlines and text messaging services may also help Aboriginal and rural contraceptive users access confidential care.

#### IMPROVE PUBLIC AND HEALTHCARE PROVIDER EDUCATION

School-based sexual health programs were cited as the “low hanging fruit” to improve family planning knowledge and empower the public. To complement school-based programs, informants suggested that we tailor appealing online and social media resources to youth and specific groups such as Aboriginal Canadians, new immigrants and people with disabilities. *“The deaf really use internet, but women need information in their [French] language. This would cost so little and make such a difference.”* (Director, non-governmental organization).

Respondents called for expanded undergraduate and continuing education family planning training programs for physicians, nurses and midwives, including updated information on abortion. The National Institute of Public Health of Quebec online family planning training program for nurses and the Ontario College of Family Physicians Advanced IUD Insertion Training Program were both cited as potential models.

## Discussion

There is remarkable congruency between the family planning barriers, inequities and solutions proposed by healthcare professionals, managers, advocacy organizations and leaders of key provincial and national stakeholder organizations. The access issues raised in this study lend themselves to a number of health services and policy solutions.

Almost every informant cited cost as the central barrier to contraception access in Canada. Health policies to provide subsidized contraception could eliminate this barrier. Such policies have been shown to be cost-beneficial in a number of jurisdictions including the US (Frost and Frohwirth 2010) and Great Britain (Frost et al. 2008; Hughes and McGuire 1996; Paton 2002) by reducing the costs of unintended pregnancy. Our results suggest that Canadian family planning providers would strongly support subsidized family planning. Quebec informants cited few financial barriers, where provincial drug insurance covers the full cost of contraception to women in high-risk groups, and otherwise subsidizes about 80% of the cost of medications, including the IUS, which costs 82.66\$ (RAMQ 2014). This is thought to explain higher uptake of IUDs in Quebec (7% vs. 4.3% elsewhere in Canada) (Black et al. 2009).

This study also highlights a call from healthcare professionals to create multiple points of entry for users to access contraception in Canada. The problematic issues of lack of professionalism and healthcare provider bias, and the special needs of rural, remote and vulnerable populations, could be addressed through multiple modalities, including expanding the number

of providers through task sharing among health disciplines such as nursing, medicine and pharmacy for prescribing of contraceptives, specialized reproductive health clinics, enhanced health professional and public education, confidential telephone hotlines and culturally relevant social media. There is a major role for public health and government in planning and delivering these services.

It is an opportune time for policy makers to promote task sharing. Evaluations of the Canadian healthcare system indicate that allied healthcare professionals are underutilized (Fyke 2001; Romanow 2002). At the same time, professional associations seem increasingly open to negotiating scope of practice and task-sharing agreements. Evidence to support this shift is quickly accruing: the Quebec Collaborative Agreement on Hormonal Contraception has greatly facilitated contraceptive access in the province (Guilbert et al., 2011, 2013a, 2013b); the uptake of emergency contraception doubled in British Columbia after regulatory change allowed direct access from pharmacists (Soon et al. 2005); pharmacists in many provinces now provide the influenza vaccine (Pearson 2007); BC pharmacists are receptive to independent prescription of hormonal contraception (Norman et al. 2013; Wong et al. 2014); and the Registered Nurses' Association of Ontario currently advocates for authorization of registered nurse prescribing (Di Costanzo et al. 2012). Over-the-counter contraception is well-aligned with the American College of Obstetricians and Gynecologist's position since 2012 (ACOG 2012). There is also strong international evidence for the safety of mid-level providers to provide medical abortion and IUD insertion (Farr et al. 1998; Jejeebhoy et al. 2011; Warriner et al. 2006).

Our study has limitations. Our convenience national sample did not allow for in-depth explorations of local policy issues. We interviewed decision-makers, managers and healthcare provider volunteers who work closely with women and couples, but who may not reflect the direct perspective of contraceptive users or the majority of contraceptive providers.

These results underscore the urgent need for a national strategic approach to family planning health policy and health services delivery in Canada. Healthcare providers, and leaders among national professional and advocacy organizations sampled, clearly indicated a need for equitable access to affordable contraceptive methods, knowledge and services in Canada, particularly among marginalized and vulnerable populations. This formative research will inform future directions for health services and policy research and equity-enhancing strategies within Canada's evolving healthcare system.

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